Vytra Student Recertification

IMPORTANT! Failure to complete this form and return it to HIP Health Plan of New York within thirty-one (31) days from the date you were contacted for the student and/or disability information will result in the termination of coverage for this dependent.

HIP-Vytra

Subscriber Attestation:

Full-time student? ____ Yes ____ No

Is this dependent handicapped? ____ Yes ____ No

Name of student**:** _____

Date of birth: _____

Name of accredited institution of learning that dependent is attending as a full-time student:

_____

Address of accredited institution of learning:

_____

_____

Phone number: ( ) - _____ - _____

Semester(s) attending: _____

Insured subscriber's name: _____

Insured subscriber's employer ID: _____ Insured subscriber's group type: _____

Insured subscriber's ID number: _____ Student's ID number: _____

Authorization:

I hereby request that the dependent named above remain covered on my health insurance policy. I certify that this dependent is an unmarried child currently attending an accredited educational institution. I certify that under penalty of perjury that all statements contained in this certification are true to the best of my knowledge. I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed the limits defined in the Insurance Law and the stated value of the claim for each such violation.

Signature of subscriber:_____ Date: _____/_____/_____

Print name:_____

Return this form to the Enrollment Department at:
HIP Health Plan of New York, P.O. Box 2794, New York, NY 10117-3255